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8
9 **BEFORE THE**
BOARD OF REGISTERED NURSING
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2010-223

13 **MARIA G. TORRE**
5205 Westport View Drive
14 San Diego, CA 92154

ACCUSATION

15 **Registered Nurse License No. 570001**

16 Respondent.

17
18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her
21 official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"),
22 Department of Consumer Affairs.

23 2. On or about August 8, 2000, the Board issued Registered Nurse License Number
24 570001 to Maria G. Torre ("Respondent"). Respondent's registered nurse license was in full
25 force and effect at all times relevant to the charges brought herein and will expire on August 31,
26 2010, unless renewed.

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STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

6. California Code of Regulations, title 16, section ("Regulation") 1442 states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

7. Regulation 1443 states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

1 FIRST CAUSE FOR DISCIPLINE

2 (Gross Negligence)

3 9. At all times herein mentioned, Respondent was employed as the Center Director for
4 Gambro Healthcare – University Avenue, an end stage renal disease facility located in San Diego,
5 California (hereinafter “Gambro Healthcare” or “facility”). Respondent was responsible for
6 ensuring the safe operation of all equipment in the facility as well as the nursing care of patients
7 in the unit, for reviewing the admissions of all new patients, and for assuring that all of her staff
8 were CPR certified.

9 10. On or about October 22, 2004, Patrick M. (hereinafter “patient”) was brought to the
10 outpatient clinic at Gambro Healthcare for his first outpatient dialysis after being hospitalized
11 with an acute illness. The patient’s pre-dialysis blood pressure was 108/48 and his pulse was 83.
12 At approximately 1:16 p.m., hemodialysis was initiated. At 1:17 p.m., the patient’s blood
13 pressure dropped to 77/41. By 1:30 p.m., the patient’s blood pressure was 67/32 and at 1:44 p.m.,
14 his blood pressure was 72/35. The patient’s symptoms of severe low blood pressure continued
15 and he lost consciousness and was foaming at the mouth. At 1:49 p.m., 36 minutes after
16 hemodialysis began, San Diego paramedics were called. The hemodialysis staff was unable to
17 locate an oxygen tank and when they finally did, it was empty. The hemodialysis staff stood by
18 watching the patient and wiped the foam from his mouth, but failed to initiate any life support
19 measures (CPR) or establish an airway. The patient was still sitting in the dialysis chair when the
20 paramedics arrived. The paramedics and fire department personnel reported that none of the
21 hemodialysis staff had initiated CPR or provided respiratory support for the patient even though
22 he was unconscious, unresponsive, and in respiratory and cardiac arrest, that the staff had not
23 brought any emergency equipment, such as a crash cart, to the patient’s chair side, and that the
24 patient’s blood pressure was 0/0, his pupils were 4 mm dilated and fixed, and his skin was
25 cyanotic. The paramedics immediately took the patient out of his chair and began CPR on the
26 floor. At 2:15 p.m., the paramedics obtained a pulse of 80 and a blood pressure of 118/74 and
27 transported the patient to Alvarado Hospital Emergency Room located in San Diego. Respondent
28 was involved in the patient’s care and made the call to the paramedics.

1 11. Respondent is subject to disciplinary action pursuant to Code section 2761,
2 subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about October 22,
3 2004, Respondent was guilty of gross negligence within the meaning of Regulation 1442, as
4 follows:

5 a. Respondent failed to assure that her staff had the requisite education, clinical
6 competency, training, and certification in CPR.

7 b. Respondent failed to initiate CPR or make any attempts to rescue the patient.

8 c. Respondent failed to obtain or use the facility's emergency equipment while the
9 patient was experiencing a medical emergency. Further, Respondent failed to assure that all
10 necessary emergency equipment was available and in working order.

11 d. Respondent failed to assess, or adequately assess, the patient while he was
12 experiencing a medical emergency, and failed to perform any interventions or provide care to
13 sustain the patient.

14 SECOND CAUSE FOR DISCIPLINE

15 (Incompetence)

16 12. Complainant incorporates by reference as though fully set forth herein the allegations
17 contained in paragraphs 9 and 10 above.

18 13. Respondent is subject to disciplinary action pursuant to Code section 2761,
19 subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about October 22,
20 2004, Respondent was guilty of incompetence within the meaning of Regulation 1443, as follows:
21 Respondent failed to assure that the documentation in the facility's clinical record was complete,
22 and that her staff documented in the patient's dialysis treatment record ("Post Treatment Report")
23 their assessment of the patient, including his appearance and respiratory, cardiac, and
24 neurological status, and their interventions in the patient's care.

25 THIRD CAUSE FOR DISCIPLINE

26 (Unprofessional Conduct)

27 14. Complainant incorporates by reference as though fully set forth herein the allegations
28 contained in paragraphs 9 and 10 above.

1 15. Respondent is subject to disciplinary action pursuant to Code section 2761,
2 subdivision (a), in that on or about October 22, 2004, Respondent committed acts constituting
3 unprofessional conduct, as set forth in paragraphs 10, 11 and 13 above.

4 PRAYER


5 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
6 and that following the hearing, the Board of Registered Nursing issue a decision:

7 1. Revoking or suspending Registered Nurse License Number 570001, issued to Maria
8 G. Torre;

9 2. Ordering Maria G. Torre to pay the Board of Registered Nursing the reasonable costs
10 of the investigation and enforcement of this case, pursuant to Business and Professions Code
11 section 125.3;

12 3. Taking such other and further action as deemed necessary and proper.

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14 DATED: 10/22/09


LOUISE R. BAILEY, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant